

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 5 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05995

CERTIFICATE OF DEATH

05990

1. DECEASED-NAME (Type or print) HARRY Samuel Bramble			2a. DATE OF DEATH Month 4 Day 14 Year 69			2b. HOUR 12:35 M					
3. SEX M		4. RACE W		5. DATE OF BIRTH 2/20/1900		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 1 HRS. HOURS 0 MIN 35	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.					
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during year of death, last year if retired) Service Station Mgr.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 706 Dover Road		
14. FATHER'S NAME First Fred J. Middle Bramble Last				15. MOTHER'S MAIDEN NAME First Ella Middle Fisher Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-03-7542		17. INFORMANT Address Mrs. Ruth M. Bramble (see 13)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Death Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Chronic Arteriosclerotic Cardiovascular Dsp. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) Emphysema											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harry Samuel Bramble, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-15-69					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4/17/69		23c. NAME OF CEMETERY OR CREMATORY Spring Hill				23d. LOCATION (City or Town) (County) (State) Easton, Talbot, Md.			
24. FUNERAL DIRECTOR Jay D. Heavrin, Easton, Md.				25a. REC'D BY REGISTRAR APR 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

05885

RECEIVED 01 07 78

2/20/1980

Service Station

100 Dover Road

Wile Street

Post 4100

210-00-1000 Mrs. John M. Brown (see 10)

RECEIVED

RECEIVED 01 07 78

RECEIVED 01 07 78

RECEIVED 01 07 78

RECEIVED 01 07 78

APR 16 1980

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05996

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Williams Garrison Brummell</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>9</i> Year <i>1969</i>			2b. HOUR <i>3:30</i> M	
3. SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>July 30, 1903</i>		6. AGE (In years last birthday) <i>65</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First <i>Maurry L.</i> Middle <i>Brummell</i> Last <i>Brummell</i>		15. MOTHER'S MAIDEN NAME First <i>ANNIE</i> Middle <i>MOORE</i> Last <i>MOORE</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-12-547</i>		17. INFORMANT <i>Mrs. Vera Brummell</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral edema</i> <i>250.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cause undetermined</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Herbiller mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>E. C. H. Schmidt</i>		22c. DATE SIGNED <i>April 9</i>		22d. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>		22e. ADDRESS <i>Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/12/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Oak Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Rose Oak Talbot Md</i>	
24. FUNERAL DIRECTOR <i>George K. Schmidt</i>		ADDRESS <i>Easton Md</i>		25a. REC'D BY REGISTRAR <i>APR 15 1969</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05997									
CERTIFICATE OF DEATH									
05992									
1. DECEASED-NAME (Type or print) <u>Richard P. Byrne</u>					2a. DATE OF DEATH <u>4</u> Month <u>27</u> Day <u>6</u> Year <u>1969</u>		2b. HOUR <u>11:25</u> M		
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>7/14/1905</u>		6. AGE (In years last birthday) <u>63</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Talbot</u> Md.			
10. CITY OR TOWN OF DEATH <u>Easton</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>SALESMAN FOOD BROKER</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>		13b. COUNTY <u>TALBOT</u>		13c. CITY OR TOWN <u>EASTON</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>107 BIERY ST.</u>	
14. FATHER'S NAME First <u>PATRICK B.</u> Middle <u>BYRNE</u> Last <u>BYRNE</u>				15. MOTHER'S MAIDEN NAME First <u>WALBURGA</u> Middle <u>HIEZ</u> Last <u>MANN</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>077-05-1193</u>		17. INFORMANT <u>MRS. RICHARD BYRNE, EASTON, MD</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Perforated duodenal ulcer</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Acute bronchitis respiratory acidosis.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-20</u> , 19 <u>69</u> , to <u>4-27</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>4-27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen P. Carney</u> DEGREE <u>M. D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>4-28-69</u>				
22d. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>					22e. ADDRESS <u>Easton, Maryland 21601</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>4/30/1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>		23d. LOCATION (City or Town) <u>EASTON, MD</u> (County) (State)			
24. FUNERAL DIRECTOR <u>Maurice E. Newman & Son Easton, Md</u>		25a. REC'D BY REGISTRAR <u>APR 30 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05998									
CERTIFICATE OF DEATH									
05993									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Martin Francis Callahan						4 Month 16 Day 1969		5:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		2/3/1912		37 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Md.		USA				Talbot			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during life)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton		RFD #1		Mechanic		Motor			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Talbot		Easton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD #1	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John C. Callahan			Delia Ann Flesk						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			220-12-1524		Mrs. Martin F. Callahan, Easton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) cardiac failure									many wks
DUE TO, OR AS A CONSEQUENCE OF									
(b) cor pulmonale									months
DUE TO, OR AS A CONSEQUENCE OF									
(c) chronic obstructive emphysema - years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
coarctation									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1959, 19, to 4-16, 1969, that (I) (we) last saw the deceased alive on 4-16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
St. Michael's Md								4-12-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
St. Michael's Md				St. Michael's Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		4/18/1969		Spring Hill		Easton, Md.			
24. PHYSICIAN DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
MAURICE E. NEUNAM & SON, Easton, Md.				APR 21 1969		Charles Judge			

1991 10 4

John F. ...

2/19/92

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05999

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05994

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>John Henry Camper</i>			2a. DATE OF DEATH Month Day Year <i>April 23 1969</i>			2b. HOUR <i>7a M</i>			
3. SEX <i>MALE</i>		4. RACE <i>NEGROID</i>		5. DATE OF BIRTH <i>4-1-UNKNOWN</i>		6. AGE (In years last birthday) ? <i>ABOUT 77</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>LABORER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>TRAPPE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>RFD, TRAPPE</i>	
14. FATHER'S NAME First Middle Last <i>LEVIN H. CAMPER</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>GEORGIANNA Tripper</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-22-7727</i>		17. INFORMANT Address <i>LAWRENCE BOOKS</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>444.2</i> <i>Mesenteric thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
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21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>E. C. H. Schmidt M.D.</i>		22c. DATE SIGNED <i>23 Apr 69</i>		22d. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>		22e. ADDRESS <i>Easton, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4-26-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>TRAPPE</i>		23d. LOCATION (City or Town) (County) (State) <i>TRAPPE TALBOT Md.</i>			
24. FUNERAL DIRECTOR <i>G. B. Washell</i>		25a. REC'D BY REGISTRAR DATE <i>APR 29 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Schmley Judge</i>					

0533

STATE OF TEXAS

COUNTY OF DALLAS

WARRANT FOR THE ARREST OF

JOHN DOE

CHARGE: OBSCENE EXPOSURE

SECTION 43.05, PENAL CODE

ISSUED: 05/15/2024

BY: J. R. SMITH

CLERK OF DISTRICT COURT

AT DALLAS, TEXAS

FOR THE YEAR 2024

FILE NO. 24-00123

WARRANT NO. 12345

RETURN TO: J. R. SMITH

CLERK OF DISTRICT COURT

AT DALLAS, TEXAS

FOR THE YEAR 2024

FILE NO. 24-00123

WARRANT NO. 12345

RETURN TO: J. R. SMITH

CLERK OF DISTRICT COURT

AT DALLAS, TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06000		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05995	
Item 13 Film 412 5/9/69 kk		CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) GEORGE A. CARROLL				2a. DATE OF DEATH 4 Month 29 Day 69 Year 12:15 M		2b. HOUR	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11-25-1886		6. AGE (In years lost birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER-PAINTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER ---		14. FATHER'S NAME First Middle Lost WILLIAM O. CARROLL		15. MOTHER'S MAIDEN NAME First Middle Lost MARY McCAULEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 218-20-4368		17. INFORMANT WILLIAM O. J. CARROLL, EASTON, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4379 IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Progressive cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ---						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 19 , 19 65 , to Apr. 29 , 19 69 , that (I) (we) last saw the deceased alive on April 15 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen P. Carney				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-29-69	
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.				22e. ADDRESS P.O. Box 929, Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/2/1969		23c. NAME OF CEMETERY OR CREMATORY WESLEY CHURCH CEMETERY		23d. LOCATION (City or Town) (County) (State) EASTON, MD	
24. FUNERAL DIRECTOR Harvey E. Newnam & Son Easton, MD				25a. REC'D BY REGISTRAR MAY 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECORDS OF DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 18 Form 412 5-22-62 MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
CLARENCE HUNTLEY CHRISTMAN						MAY 4 - 20 1969		M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
M	W	JAN 30, 1890	79 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR		
ILLINOIS		USA				TALBOT		M		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
ST MICHAELS RURAL			++++							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD			TALBOT		STMICHAELS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
JULIUS F CHRISTMAN			LAURA JAMES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO			067-07-5953		WALDINE S. CHRISTMAN, ST. MICHAELS, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Cardiac dilatation, focal myocardial										
4299 DUE TO, OR AS A CONSEQUENCE OF fibrosis and focal anemia										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
NONE								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			M.D. ASSISTANT MEDICAL EXAMINER			4-22-69				
LOUIS S. WELTY			ACTING DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
CREMATION		APR 22, 1969		FT. LINCOLN CEMETERY		WASHINGTON, D. C.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Thurston E. Leonard				ST. MICHAELS, MD.		APR 25 1969		O. Charles Judge		

FOR STATE
NOTED OUT

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GENERAL EXAMINER'S CERTIFICATE OF DEATH

CLARENCE HUNTLEY CHRISTIAN

DECEASED
ST. LOUIS, MO.
JANUARY 1, 1900

WILLIAM T. HUNTLEY

X

10000

LOUIS A. KELLY

ST. LOUIS, MO.

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06002

CERTIFICATE OF DEATH

05997

1. DECEASED-NAME (Type or print) <i>Mary B Cooper</i>		2a. DATE OF DEATH 4 Month 13 Day 69 Year		2b. HOUR 1 P M
3. SEX <i>Female</i>	4. RACE <i>Ngro</i>	5. DATE OF BIRTH <i>May 15 1895</i>		6. AGE (In years last birthday) 73 YRS.
7a. BIRTHPLACE (State or foreign country) <i>md</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i> Md.	
10. CITY OR TOWN OF DEATH <i>EASTON</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Domestic</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>	13b. COUNTY <i>Talbot</i>	13c. CITY OR TOWN <i>Whitman</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>Whitman md</i>
14. FATHER'S NAME First <i>Elmer</i> Middle <i>Johnson</i> Last <i>Johnson</i>	15. MOTHER'S MAIDEN NAME First <i>Ann</i> Middle <i>Johnson</i> Last <i>Johnson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	16b. SOCIAL SECURITY NO. <i>220-32-2411</i>	17. INFORMANT Address <i>James Cooper Whitman md</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertensive Arteriosclerotic C.V.D. 15 yr</i> (b) <i>Granulosis Pulmonis</i> (c) <i>15 yr</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.E.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>April 9 1969</i> , to <i>April 13 1969</i> , that (I) (we) last saw the deceased alive on <i>April 12 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.				
22b. SIGNATURE <i>R. Lane Wroth</i>	DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4-17-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>R. Lane Wroth</i>	22e. ADDRESS <i>St. Michaels, Md. 21663</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4/17/69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Richards Com</i>	23d. LOCATION (City or Town) (County) (State) <i>EASTON TA. md</i>	
24. FUNERAL DIRECTOR <i>George H. Dabbs</i>	ADDRESS <i>Easton md</i>	25a. REC'D BY REGISTRAR DATE <i>APR 18 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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CERTIFICATE OF DEATH
IN THE CITY OF NEW YORK
JANUARY 1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A1514
30M REV. 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06003

CERTIFICATE OF DEATH

05998

1. DECEASED-NAME (Type or print) First HATTIE Middle MAY Last DARLING			2a. DATE OF DEATH Month 4 Day 24 Year 69			2b. HOUR 10³⁰ M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 1895		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Hurlock, Md..		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D. #1	
14. FATHER'S NAME First Unknown Middle Last 			15. MOTHER'S MAIDEN NAME First Maggie Middle Hurlock Last 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mrs. Margaret Dolby, Preston, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia - cause undetermined 038.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36h	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 24 Apr , 19 69 , to 24 April , 19 69 , that (I) (we) last saw the deceased alive on 24 Apr , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thorston Harrison M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 25 Apr 69					
22d. PHYSICIAN'S NAME (Type) THORSTON HARRISON				22e. ADDRESS Easton, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE April 27, 1969		23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery		23d. LOCATION (City or Town) (County) (State) Preston, Maryland			
24. FUNERAL DIRECTOR J.J. Frampton & Son, Federalsburg, Md ADDRESS 				25a. REC'D BY REGISTRAR APR 30 1969 DATE		25b. REGISTRAR'S SIGNATURE William Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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06004

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05999

1. DECEASED-NAME (Type or Print) EDDIE First FRANCIS Middle DEAN Last SR. <i>Eddie Dean</i>		2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 4/28/1969		2b. HOUR 3:25 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 22, 1903	6. AGE (In years last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Talbot Md.
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auto Mechanic
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Caroline	13c. CITY OR TOWN Preston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Tilghman A. Dean		15. MOTHER'S MAIDEN NAME First Middle Last Daisey M. Murphy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mary Jane Stolzenbach, Federalsburg, Md., RFD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 starvation DUE TO, OR AS A CONSEQUENCE OF malnutrition (b) 4mos DUE TO, OR AS A CONSEQUENCE OF Bronchogenic Carcinoma with metastasis (c) 6mos				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>[Signature]</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/30/69
EXAMINER'S NAME (Type) Harold B. Plummer M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Preston Caroline		ADDRESS (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 1, 1969	23c. NAME OF CEMETERY OR CREMATORY Concord Cemetery	23d. LOCATION (City or Town) (County) (State) Near Federalsburg, Maryland	
24. FUNERAL DIRECTOR W. Hampton and Son, Federalsburg Md.		25a. REC'D BY REGISTRAR DATE MAY 6 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

20020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
30M REV. 1-68

06005		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06000	
Item 6 Film 411 4/24/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First Middle Last Arthur Charles Dodge		2a. DATE OF DEATH Month Day Year April 18, 1969	
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 17, 1880	
6. AGE (In years last birthday) 88 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Talbot		10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deep Water Point	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Civil Eng.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Charles D. Dodge		15. MOTHER'S MAIDEN NAME First Middle Last Arta Snyder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 37507-3102		17. INFORMANT Address Mr. John D. Dodge Box 521, Easton	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mrs. 1 year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 3/18, 1969, to 4/18, 1969, that (I) (we) last saw the deceased alive on 4/13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Robert M. McDonald MD DEGREE 22c. DATE SIGNED 4/18/69	
22d. PHYSICIAN'S NAME (Type) Robert M. McDonald MD		22e. ADDRESS Box 43, Oxford, Maryland 21654		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE April 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Old Mt. Zion	
23d. LOCATION (City or Town) (County) (State) Edge Mills P.O. Md		24. FUNERAL DIRECTOR ADDRESS Easton, Md		25a. REC'D BY REGISTRAR DATE APR 21 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge					

00005

Attn: Charles Jones

April 18, 1952

April 17, 1952

White

White

White

White

White

April 18, 1952

April 17, 1952

Deep Water Point

Deep Water Point

Eastern

Eastern

Eastern

April 18, 1952

Charles E. Jones

Mr. John L. Jones, Box 281, East of

W. H. Jones & Co. Inc.
P.O. Box 281, East of W. H. Jones & Co. Inc.

Box 281, East of W. H. Jones & Co. Inc.

Robert V. McDonald, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15M
30M REV. 1-68

06006										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06001									
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH										2b. HOUR									
HARRY M EVANS										4 Month 12 Day Year 69										9:15 AM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Male			White			October 31, 1891			77 YRS.			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			USA						Talbot																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Easton			Memorial Hosp. Talbot			Foundryman & Machinist			Foundry																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Maryland			Talbot			St. Michaels						Talbot Street																	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
John S. Evans					Elizabeth Slining																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
Yes					218-12-1102					Louise L. Evans, St. Michaels, Maryland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF										Cerebral Hemorrhage																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF										Arteriosclerotic Cardiovascular Disease																			
(c) DUE TO, OR AS A CONSEQUENCE OF																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from April 1969, to April 1969, that (I) (we) last saw the deceased alive on April 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE R. Lane Wroth M.D.										22c. DATE SIGNED 4-19-69																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
										St. Michaels, Md. 21663																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					April 14, 1969					Woodlawn Memorial Park					Baston, Maryland														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Harmon E. Leonard St. Michaels Md										APR 21 1969										[Signature]									

00000

RECORD OF DEATH

Name: [illegible] Date: [illegible]

Sex: [illegible] Age: [illegible]

Place of Birth: [illegible]

Occupation: [illegible]

Cause of Death: [illegible]

Time of Death: [illegible]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06007		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06002	
Item 5 Film 411 4/11/69 kk					
1. DECEASED-NAME (Type or print) First Middle Last			2a. DATE OF DEATH		2b. HOUR
Margaret R Evernham			4 Month 3 Day Year 69		2:15 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
F	W	10/15/1900		68 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH
MD		USA			Talbot Md.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Easton		Memorial Hospital			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
MD		CAROLINE DENTON			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
HOWARD PASTORFIELD		MARY EMERSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.	17. INFORMANT Address		
NO			MRS BYRON NUTTLE DENTON MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung					3 mo
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
Cervical atherosclerotic heart disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1/24/65, to 3/24/69, that (I) (we) lost saw the deceased alive on 3/24/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Thorston Harrison M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		3/24/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
THORSTON HARRISON		Easton Maryland			
23a. DATE OF BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Buried last		Apr. 5, 1969		SILVERBRAKE	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles V. Moore Denton Md		DATE APR 7 1969		Charles Judge	

Dr. J. H. H. H. H.

Dr. J. H. H. H. H.

Dr. J. H. H. H. H.

Dr. J. H. H. H. H.

Dr. J. H. H. H. H.

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Dr. J. H. H. H. H.

Dr. J. H. H. H. H.

Dr. J. H. H. H. H.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06008

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06003

1. DECEASED-NAME (Type or Print) <i>LISA</i> First <i>CALDWELL</i> Middle <i>FARLEY</i> Last			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <i>4</i> Day <i>3</i> Year <i>1969</i>			2b. HOUR <i>6:30</i> M				
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>OCT, 31, 1958</i>		6. AGE (In years last birthday) <i>9</i> YRS.		7c. DATE PRONOUNCED DEAD Month <i>19</i> Year <i>19</i> M		
7a. BIRTHPLACE (State or foreign country) <i>KY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.				
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>STUDENT</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>			13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>EASTON</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>RT #3 Box 166</i>	
14. FATHER'S NAME First <i>C. AUSTIN</i> Middle <i>FARLEY</i> Last <i>JR.</i>			15. MOTHER'S MAIDEN NAME First <i>MARY JANE</i> Middle <i>REYNOLDS</i> Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. <i>NONE</i>	
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			17. INFORMANT <i>C. AUSTIN FARLEY, JR., EASTON, MD</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured skull + Multiple Injuries</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thrown + dragged by horse</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>906X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>6:43 P.M. 4 3 1969</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Thrown + stirred dragged by horse</i>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home farm</i>			21f. LOCATION Street or R.F.D. No. <i>W. EASTON</i>		City or town <i>TALBOT</i>		County <i>md</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Louis J. Welty</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>4-4-69</i>			EXAMINER'S NAME (Type) <i>WELTY</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>			23b. DATE <i>4/7/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LEXINGTON</i>			23d. LOCATION (City or Town) (County) (State) <i>LEXINGTON, KENTUCKY</i>		
24. FUNERAL DIRECTOR <i>MAURICE E. NEWNAM, JR., EASTON, MD</i>						25a. REC'D BY REGISTRAR <i>APR 9 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

20030

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MEASUREMENT

MEASUREMENT OF STATE OF OHIO

MEASUREMENT OF STATE OF OHIO

2003 2 17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06009 CERTIFICATE OF DEATH 06004									
1. DECEASED-NAME (Type or print) Howard Marion Fish			2a. DATE OF DEATH Month April Day 25 Year 1969			2b. HOUR 50 M			
3. SEX MALE		4. RACE white		5. DATE OF BIRTH 10-6-1906		6. AGE (In years last birthday) 62 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Gasoline Service Station			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Operator 118 Harrison Street	
14. FATHER'S NAME First Howard Middle Fish Last Fish			15. MOTHER'S MAIDEN NAME First Lucy Middle (maiden name unknown) Last 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 218-16-5369		17. INFORMANT Address Robert M. Fish, Federalsburg, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 24 apr, 1969 , to 25 apr, 1969 , that (I) (we) last saw the deceased alive on 25 apr 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen P. Carney				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-26-69			
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.				22e. ADDRESS Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE April 28, 1969		23c. NAME OF CEMETERY OR CREMATORY Dagsboro Memorial Cemetery, Dagsboro Delaware		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Trampten		ADDRESS Trampten Funeral Home, Federalsburg, Md.		25a. REC'D BY REGISTRAR APR 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (1)
30M REV. 1-7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06010 CERTIFICATE OF DEATH 06005									
1. DECEASED-NAME (Type or print) <i>Elgie</i> First Middle Last			2a. DATE OF DEATH 4 Month 18 Day 69 Year			2b. HOUR 10P M			
3. SEX <i>FEMALE</i>		4. RACE <i>NEGROID</i>		5. DATE OF BIRTH 8/2/1902		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Glenwood Heights</i>	
14. FATHER'S NAME First Middle Last <i>John Stanley</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Maria Newnam</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>215 14 3986</i>		17. INFORMANT Address <i>Samuel C. Greene, Glenwood Heights, Easton, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> <i>4369</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>69</i> , to <i>April</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1 March 19 69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Stephen P. Carney</i> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-19-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>				22e. ADDRESS <i>Memorial Hospital Easton, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/23/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Trappe</i>		23d. LOCATION (City or Town) (County) (State) <i>Trappe Talbot Maryland</i>			
24. FUNERAL DIRECTOR <i>Barbara L. Dashiell</i> <i>Dashiell Funeral Home</i>				ADDRESS <i>426 Dover Easton, Md.</i>		25a. REC'D BY REGISTRAR <i>APR 22 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

01020

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

February 1, 1910

Dear Sir:

I have the honor to acknowledge the receipt of your letter of January 28, 1910, in relation to the matter of the proposed amendment to the act of March 3, 1879, relating to the collection of duties on foreign goods.

The act of March 3, 1879, relating to the collection of duties on foreign goods, is a public law of the United States, and is not subject to amendment by the Executive branch of the Government.

Very respectfully,
Secretary

Enclosed for you are two copies of the act of March 3, 1879, relating to the collection of duties on foreign goods, as amended by the act of March 3, 1879, and the act of March 3, 1879, relating to the collection of duties on foreign goods, as amended by the act of March 3, 1879.

I am, Sir, very respectfully,
Very truly yours,
Secretary

Very truly yours,
Secretary

Very truly yours,
Secretary

Very truly yours,
Secretary

Very truly yours,
Secretary

Very truly yours,
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Very truly yours,
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Very truly yours,
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Very truly yours,
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Very truly yours,
Secretary

Very truly yours,
Secretary

1023

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Film 4/9/69k Maryland STATE DEPARTMENT OF HEALTH											
06012 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) ^{First} ZENA ^{Middle} REBECCA ^{Last} HUBBARD						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 Day 3 Year 1969			2b. HOUR 1:30 PM		
3. SEX F		4. RACE N		5. DATE OF BIRTH 1903 7/17/69		6. AGE (In years birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT			Md.
10. CITY OR TOWN OF DEATH EASTON RURAL				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DUA MEMORIAL HOSP.				12a. USUAL OCCUPATION (Kind of work done during usual of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland						13b. COUNTY Talbot		13c. CITY OR TOWN Williams-		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Rt. # 50, Near Easton											
14. FATHER'S NAME ^{First} William ^{Middle} Stanley ^{Last} Racheal				15. MOTHER'S MAIDEN NAME ^{First} Cornish ^{Middle} ^{Last}							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 220 03 8410		17. INFORMANT ADDRESS Maryland Nelson Stanley, East New Market					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 814.7 MULTIPLE SEVERE INJURIES DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AUTO ACCIDENT DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 4-3-69 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) struck by car walking on highway			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hiway Rte 50				21f. LOCATION Street or R.F.D. No. City or Town County State South of Easton Talbot Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Louis S. Welty</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 4-3-69			
EXAMINER'S NAME (Type) Louis S. Welty				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 4/8/69		23c. NAME OF CEMETERY OR CREMATORY Federalsburg				23d. LOCATION (City or Town) (County) (State) Federalsburg Maryland	
24. FUNERAL DIRECTOR B. L. Dashiell, Funeral Home 426 Dover Easton, Maryland						25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

1921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06013

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06008

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First Herbert	Middle Eugene	Last Jump	2a. DATE OF DEATH Month April Day 15 Year 1969			2b. HOUR M		
3. SEX male		4. RACE white		5. DATE OF BIRTH October 28, 1894		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot			Md.		
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 221 S. Harrison		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Actuary		12b. KIND OF BUSINESS OR INDUSTRY various					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 221 S. Harrison			
14. FATHER'S NAME First William			Middle F. Jump			15. MOTHER'S MAIDEN NAME First Maria			Middle Warren		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-03-7489		17. INFORMANT Mrs. Herbert E. Jump			Address Easton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 10 minutes < 30 minutes > 5 1/2 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from October, 1963 , to 4-15, 1969 , that (I) (we) lost the deceased alive on 3-21, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert W. Trever					M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-17-69				
22d. PHYSICIAN'S NAME (Type) ROBERT W. TREVER, M.D.					22e. ADDRESS RD 3 Easton, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE APRIL 18, 1969		23c. NAME OF CEMETERY OR CREMATORY SPRINGHILL CEMETERY		23d. LOCATION (City or Town) EASTON		(County) TALBOT MD.		(State)	
24. FUNERAL DIRECTOR [Signature]					ADDRESS EASTON, MARYLAND		25a. REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

31020

ROBERT W. LEEVER, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06014

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06009

1. DECEASED-NAME (Type or print) VIRGINIA K KNOTTS			2a. DATE OF DEATH Month 4 Day 16 Year 69			2b. HOUR 7:40 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 8/31/1931		6. AGE (In years last birthday) 37 YRS.	
7a. BIRTHPLACE (State or foreign country) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWORK		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 628 GOLDSBORO ST							
14. FATHER'S NAME First Middle Last J. CLEMENT KOSINSKE			15. MOTHER'S MAIDEN NAME First Middle Last LILLIAN A. SAVIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (or, of unknown) NO		16b. SOCIAL SECURITY NO. 314-30-8203		17. INFORMANT Address VAUGHN D. KNOTTS, EASTON, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Path metastasphosis of liver 571.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital), attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E.C.H. Schmitt		22c. PHYSICIAN'S NAME (Type) E.C.H. Schmitt		22d. ADDRESS Easton, Md.		22e. DATE SIGNED 12 April 69	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/19/1969		23c. NAME OF CEMETERY OR CREMATORY WOODLAND MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) EASTON, MD	
24. FUNERAL DIRECTOR Maurice A. Neumannson		ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06015

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06010

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Charles F. Lindsay</i>			2a. DATE OF DEATH Month <i>4</i> Day <i>7</i> Year <i>69</i>			2b. HOUR <i>7:20</i> AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 14, 1885		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.					
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Queen Anne's			13c. CITY OR TOWN Millington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER -----	
14. FATHER'S NAME First Middle Last Charles Lindsay			15. MOTHER'S MAIDEN NAME First Middle Last May C. Moots.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No.			16b. SOCIAL SECURITY NO. 213-20-6246			17. INFORMANT Address Walter I. Lindsay, Millington, Md. 21651					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Parkinsonism 342X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Uncertain											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) none											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> , NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>4-7</i> , 19 <i>69</i> , to <i>4-7</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4-7</i> , 19 <i>69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert W. Trever</i> M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-8-69			
22d. PHYSICIAN'S NAME (Type) Robert W. Trever, M.D.						22e. ADDRESS Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April, 10, 1969		23c. NAME OF CEMETERY OR CREMATORY Millington Cemetery.			23d. LOCATION (City or Town) (County) (State) Millington, Kent, Md.				
24. FUNERAL DIRECTOR <i>Edward Elbar</i> Millington Md ADDRESS						25a. REC'D BY REGISTRAR APR 14 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

05015

STATE OF TEXAS

County of _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last					Month Day Year			Hour Min		
EDITH RACHEL MARSHALL					April 14, 1969			11:48 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		White		March 23, 1902		67 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Talbot County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Wittman			-----			Housewife		-----		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Talbot		Wittman		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		-----	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
Henry Pollard					Ella Harrington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			220-01-4597		Percy R. Marshall, Wittman, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemic Cardiovascular Dis. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June, 1968, to April 14, 1969, that (I) (we) last saw the deceased alive on April 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. Lane Wroth, M.D.					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-17-69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
R. LANE WROTH, M. D.					St. Michaels, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		April 17, 1969		Olivet Cemetery		St. Michaels, Maryland				
24. FUNERAL DIRECTOR Hanson E. Leonard, St. Michaels, Md.					25a. REC'D BY REGISTRAR DATE 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

88016

STATE OF NEW YORK

IN SENATE

1900

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

ON JANUARY 10, 1899

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS, 1899.

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be the main body of the report, containing various sections and possibly a table of contents or a list of items.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

06017

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film 411 4/11/69 kk

CERTIFICATE OF DEATH

06012

1. DECEASED-NAME (Type or print) NICHOLAS			First Middle Last			2a. DATE OF DEATH Month 4 Day 1 Year 69			2b. HOUR 5:30 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DEC 6, 1891		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) GREECE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.					
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SERVICE STATION			12b. KIND OF BUSINESS OR INDUSTRY GAS		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE MD			13b. COUNTY CAROLINE			13c. CITY OR TOWN MARYDEL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last UNKNOWN			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address Mrs EFFIE OSTERBURG, MONROE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. C. H. Schmidt		DEGREE - MD		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3 April 69					
22d. PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22e. ADDRESS Easton, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APR 4, 1969		23c. NAME OF CEMETERY OR CREMATORY THE EVERGREENS		23d. LOCATION (City or Town) (County) (State) BRIDGELAND N.Y.					
24. FUNERAL DIRECTOR CHARLES V. MOORE		ADDRESS DENTON, MD.		25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

00017

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	
Sex		Race	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Entry		Date of Filing	

00017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06018		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06013	
Items 5&6 Film G413 5/29/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) Henry L. Neal			2a. DATE OF DEATH 4 Month 21 Day 69 Year 6:25 A.M.		2b. HOUR
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7-18-94 1895		6. AGE (In years last birthday) 73 1/4 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Talbot		
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the Pines		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. USUAL RESIDENCE (Where deceased lived/admission) STATE MD.	13b. CITY OR TOWN CAROLINE	13c. CITY OR TOWN R.F.D.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER N/A.	
14. FATHER'S NAME CHARLES R. NEAL		15. MOTHER'S MAIDEN NAME GULAH E. BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 220-32-1227		17. INFORMANT SHERMAN NEAL BRIDGEVILLE DEL.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4379 IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Progressive cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 3 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 5, 1966 , to Apr. 21, 1969 , that (I) (we) last saw the deceased alive on April 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Stephen P. Carney		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 4-21-69	
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.		22e. ADDRESS P.O. Box 929, Easton, Md. 21601			
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-23-69		23c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery	
24. FUNERAL DIRECTOR Harvey Williamson		ADDRESS Federalsburg Md.		23d. LOCATION (City or Town) (County) (State) Federalsburg Caroline Md.	
25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

STATE OF TEXAS
COUNTY OF DALLAS
JAN 18 1900

WITNESSES
J. M. [illegible]
[illegible]

NOTARY PUBLIC
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06019 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) JOHN T. NEWCOMB			2a. DATE OF DEATH Month 4 Day 24 Year 69			2b. HOUR 8:55 M			
3. SEX MALE		4. RACE NEGROE		5. DATE OF BIRTH Mar. 25, 1897		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TA/60T Md.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD#3, Box 147	
14. FATHER'S NAME First Samuel Middle Newcomb Last Maggie			15. MOTHER'S MAIDEN NAME First Hubbard Middle Lost						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 221 16 7437		17. INFORMANT Address Maryland Edward Newcomb, RFD#3, Box 147, Easton					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1541 (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Miles resection for Ca of rectum								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 5 days 2 months?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 4/16/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of rectum			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-11-69 , to 4/24-69 , that (I) (was) last saw the deceased alive on 4/24-69 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.									
22b. SIGNATURE J.T.B. Ambler				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/25/69	
22d. PHYSICIAN'S NAME (Type) J.T. B. Ambler				22e. ADDRESS Easton, Maryland 21601					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/28/69		23c. NAME OF CEMETERY OR CREMATORY Zoar Methodist		23d. LOCATION (City or Town) (County) (State) Preston Caroline Maryland			
24. FUNERAL DIRECTOR J. B. Dashiell				ADDRESS 436 Dory St		25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

00010

RECEIVED BY MAIL

RECEIVED BY MAIL

RECEIVED BY MAIL

RECEIVED BY MAIL

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div> <div>Item 5 Filing 4/11</div> <div>4/21/69 kk</div> <div>06020</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>06015</div> </div>										
1. DECEASED-NAME (Type or Print)		First R.		Middle Rison		Last North		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> April 12 1969		2b. HOUR A M
3. SEX M.	4. RACE W.	5. DATE OF BIRTH Feb. 24, 1894		6. AGE (In years last birthday) 75 RS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD April 12, 1969		2d. HOUR M
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot		Md.		
10. CITY OR TOWN OF DEATH Easton.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 107 Tred Avon Ave.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Auditor		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 107 Tred Avon Ave.		
14. FATHER'S NAME First Robert		Middle R.		Last North		15. MOTHER'S MAIDEN NAME First Nodie		Middle Covington		Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-36-1537		17. INFORMANT John-Clarence North				ADDRESS Easton, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) 										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Louis S. Welty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 4-14-69				
EXAMINER'S NAME (Type) LOUIS S. WELTY		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				ACTING DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City or Town) East on		(County) Talbot	(State) Md	
24. FUNERAL DIRECTOR John Clark				ADDRESS Easton, Md		25a. REC'D BY REGISTRAR APR 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

100-36-1517

FOR RAIL
RECORDS

March 1942

April 12, 1942

U. S. A.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 11/68

06021		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06016	
Item 1 Film 411 4/24/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) Edgar		First Middle Last Ravenneh		2a. DATE OF DEATH Month 7 Day 14 Year 69	
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 9-18-1903	
7a. BIRTHPLACE (State or foreign country) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (In years last birthday) 65 YRS.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) waiter	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton	
14. FATHER'S NAME First Middle Last Emile J. Ravenneh		15. MOTHER'S MAIDEN NAME First Middle Last Sadie McGill		12b. KIND OF BUSINESS OR INDUSTRY None	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 212-07-6010		17. INFORMANT Baltimore, Maryland Address Sadie Saunders 3702 Woodbine Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1419 Ixemia		DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma throat		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of tongue		6 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				2 yrs.	
19a. DATE OF OPERATION Nov 1967		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of tongue		20a. AUTOPSY? YES NO X	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21d. INJURY OCCURRED While Not while at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
22a. I certify that (I) (this hospital) attended the deceased from Nov 1967, to 4/14, 1969, that (I) (we) last saw the deceased alive on 4/14/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE J T B Ambler		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Dr. J T B Ambler		22e. ADDRESS Easton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/19/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	
24. FUNERAL DIRECTOR J T B Dashiell		25a. READ BY REGISTRAR APR 22 1969		25b. REGISTRAR'S SIGNATURE	

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U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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JAN 10 1911
U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06022

06017

FOR STATE HEALTH DEPT.

1. DECEASED NAME (Type or Print) <i>John Vernon Rose</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 4 15 1969 MATED <input type="checkbox"/> 4 15 1969			2b. HOUR 3:30 P.M.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12/9/1923	6. AGE (In years last birthday) 45 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 19 M			
7a. BIRTHPLACE (State or foreign country) Cambridge Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Talbot			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unable to work		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWN Dorchester Cambridge		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 400 Light St.			
14. FATHER'S NAME First Middle Last John W. Rose			15. MOTHER'S MAIDEN NAME First Middle Last Lavinia Greene						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. WW2 201-10-0029		17. INFORMANT ADDRESS Mrs. W. Howard Dail Cambridge Md. 21613				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple severe injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Auto accident DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR:AM- 4:10 P.M. 4-15 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Car struck R.R. culvert				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Strut in		21f. LOCATION Street or R.F.D. No. City or Town County State Easton Talbot Sm					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Louis O'Neely</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4-16-69			
EXAMINER'S NAME (Type) WELTY			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county) Cambridge Md. 21613									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/18/1969		23c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		23d. LOCATION (City or Town) (County) (State) Cambridge Dorchester			
24. FUNERAL DIRECTOR <i>Benjamin R. Thorne Jr.</i>				ADDRESS Cambridge Md. 21613		25a. REC'D BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06033

Male White 12/9/1923 12

Cambridge MA. U.S.

Unemployed

Mr. Rochester Cambridge MA 100 State St.

John W. Boston

W2

501-10-0029 Mrs. J. Howard Tall Cambridge MA. 2101

1/18/1952 Cambridge Cemetery

Cambridge MA. 2101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06023

CERTIFICATE OF DEATH

06018

1. DECEASED-NAME (Type or print) <i>Wester</i>		First	Middle	Lost	2a. DATE OF DEATH 4 Month Day 19 Year 69		2b. HOUR 8A M
3. SEX <i>Male</i>	4. RACE <i>Wegro</i>		5. DATE OF BIRTH <i>Jan. 2, 1910</i>		6. AGE (In years lost birthday) <i>59</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.	
10. CITY OR TOWN OF DEATH <i>Royal Oak</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Water man</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>Royal Oak</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>Royal Oak MD</i>	
14. FATHER'S NAME <i>Frank</i>		First	Middle	Lost	15. MOTHER'S MAIDEN NAME <i>Verdie Jenkins</i>		First Middle Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>215-163642</i>	17. INFORMANT <i>Evelyn T. Ross</i> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction sudden</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>atherosclerotic</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>cardio vasd.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1963</i> , 19____, to <i>11-15</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4-15</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Wm. B. Beeler</i> MD		22c. DATE SIGNED <i>4-21-69</i>		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>St. Michael's Med -</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4/22/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Royal Oak</i>		23d. LOCATION (City or Town) (County) (State) <i>Royal Oak Tal. Md</i>	
24. FUNERAL DIRECTOR <i>George A. Michael Carter md</i>				25a. REC'D BY REGISTRAR <i>APR 24 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

00000

STATE OF TEXAS

1904

County of ... State of Texas
I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.

Witness my hand and the seal of said County at the City of ... this ... day of ... 1904.

+

1904

1903

1902

County of ... State of Texas
I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06024		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
Item 13 Film 412 4/30/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH	
HANNAH B. SHARRETTS				April 15, 1969	
3. SEX	female	4. RACE	white	5. DATE OF BIRTH	May 30, 1869
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	
		USA		Talbot	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Easton		House in The Pines		Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
Md.		Kent Q.A.	Chestertown		Box 135
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
First Middle Last		First Middle Last			
Joseph Bennanzer		Julia Ritter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
no		220 44 8082		Roland Sharretts Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Progressive cerebral arteriosclerosis</i>					10 yrs
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
<i>Chronic meningitis infection, chronic cholecystitis</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
	HOUR A.M. Month Day Year				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION			
White <input type="checkbox"/> Not white <input type="checkbox"/>		Street or R.F.D. No. City or Town County State			
at work <input type="checkbox"/> at work <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from <i>4-24</i> , 19 <i>64</i> , to <i>4-15</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>4-3</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED
<i>Stephen J. Carey</i>			<input checked="" type="checkbox"/>		<i>4-16-69</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
		Easton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial	4/18/69	Druid Ridge Cem.		Baltimore, Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
<i>J. Wilho Wells</i>		Chestertown, Md.		APR 21 1969	<i>William L. Indle</i>

38080

RECEIVED 12 JAN 68 10 10 AM 1968

U.S. AIR FORCE

11:00

11:00

11:00

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a teletype or a very poor quality scan of a document.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06025

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06020

1. DECEASED-NAME (Type or Print) <i>Mary Ruth Smith</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>April</i> Day <i>28</i> Year <i>1969</i>			2b. HOUR <i>10:38</i> PM		
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Jan. 26, 1896</i>	6. AGE (In years last birthday) <i>73</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>April</i> Day <i>28</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>		
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Memorial Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>U.S. Rt. 50</i>	
14. FATHER'S NAME First <i>Wilton K.</i> Middle <i>Edwards</i> Last <i>Edwards</i>				15. MOTHER'S MAIDEN NAME First <i>Annie</i> Middle <i></i> Last <i></i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>LeCompte Funeral Service records</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Lemir Welty</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>5-1-69</i>		
EXAMINER'S NAME (Type) <i>WELTY</i>			M.D. <i>acty</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>May 2, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Joppa Churchyard</i>		23d. LOCATION (City or Town) (County) (State) <i>Madison, Maryland</i>		
24. FUNERAL DIRECTOR <i>LECOMPT FURNERAL SCTR, CAMBRIDGE, MD</i>				25a. REC'D BY REGISTRAR <i>1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

08032

MEDICAL EXAMINER CERTIFICATE OF DEATH

Jan. 26, 1930

City of London

London & County

In London & County of London

1930

1930

1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06026

06021

1. DECEASED-NAME (Type or print) First Middle Last BROOKSIE W. SPEAR			2a. DATE OF DEATH Month Day Year 4 20 69			2b. HOUR 9:10 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 7-12-93		6. AGE (In years last birthday) YRS. 75	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NURSING		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. CITY OR TOWN DORCHESTER		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER N/A	
14. FATHER'S NAME First Middle Last TOM THOMAS			15. MOTHER'S MAIDEN NAME First Middle Last IDA E. GOSLIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 218-20-4266		17. INFORMANT Address ROBERT ENGLISH, SEAFORD, DEL.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatal and diffuse peritonitis 1533 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of sigmoid bowel DUE TO, OR AS A CONSEQUENCE OF (c) resected.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE E. C. H. Schmidt		22c. DATE SIGNED 21 Apr. 69		22d. PHYSICIAN'S NAME (Type) E. C. H. Schmidt			
22e. ADDRESS Easton, Maryland		22f. ADDRESS Easton, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-24-69		23b. DATE 4-24-69		23c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery		23d. LOCATION (City or Town) (County) (State) Brookview, Dorchester, Md.	
24. FUNERAL DIRECTOR Howell Williams		24a. ADDRESS Frederick, Md.		25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

00038

RECEIVED

RECEIVED

1961



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06027

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06022

1. DECEASED-NAME (Type or Print) <i>Arthur Walter Thomas</i>		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>4-8-69</i>		2b. HOUR <i>7:40</i> M
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>11/13/44</i>	6. AGE (In years last birthday) <i>24</i> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) <i>Salisbury, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i>
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Construction Worker</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Caroline</i>	13c. CITY OR TOWN <i>Denton</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First <i>Emerson</i> Middle <i>Nichols</i> Last <i>Thomas</i>		15. MOTHER'S MAIDEN NAME First <i>Otelia</i> Middle <i>Thomas</i> Last <i>Thomas</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>0</i>		17. INFORMANT <i>Mrs. Saundra M. Thomas, Denton, Md. R.F.D.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>916X</i> (b) <i>Severe external Cardiac injury</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Junk car fell on his chest</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>minutes</i> <i>minutes</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>4/8/69</i> HOUR A.M. <i>4:45</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Chest Jack slipped on car and car fell on</i>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>R.D.#2 Denton Maryland Home of Charles Gray Denton Maryland</i>		21f. LOCATION Street or R.F.D. No. <i>County</i> <i>State</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>Harold B. Plummer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>4/11/69</i>
EXAMINER'S NAME (Type) <i>Harold B. Plummer M.D.</i>		ADDRESS (Street, city, town, or county) <i>Preston Caroline</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>April 12, 1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Federal Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Federalburg, Caroline, Md.</i>	
24. FUNERAL DIRECTOR <i>Frampton Funeral Home,</i>		ADDRESS <i>Federalburg, Md.</i>		25a. REC'D BY REGISTRAR <i>APR 16 1969</i>
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

72020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06028

CERTIFICATE OF DEATH

06023

1. DECEASED-NAME (Type or print) AUBAY First Middle Last			2a. DATE OF DEATH 4 Month 6 Day 69 Year			2b. HOUR 2:39A M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 31-1903		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.				
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memoria			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY G.A. GRASONVILLE		13c. CITY OR TOWN GRASONVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER xx	
14. FATHER'S NAME First Middle Last WILLIAM E. KING			15. MOTHER'S MAIDEN NAME First Middle Last DRUCILLA COLLIER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. xx		17. INFORMANT Address WILMER THOMPSON - GRASONVILLE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 398 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ventricular tachycardia DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 1 Hour >10 years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July , 19 69 , to 4-6 , 19 69 , that (I) (we) last saw the deceased alive on April 6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert W. Trever, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED April 6, 1969					
22d. PHYSICIAN'S NAME (Type) Robert W. Trever M.D.					22e. ADDRESS Easton, Maryland 21601					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APRIL 9		23c. NAME OF CEMETERY OR CREMATORY STEVENSVILLE		23d. LOCATION (City or Town) (County) (State) STEVENSVILLE MD				
24. FUNERAL DIRECTOR Harold Funeral Home, Pouch A.M. Md.					25a. REC'D BY REGISTRAR DATE APR 11 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

STANDARD FORM NO. 64

00000

TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF STAFF
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text.]



FOR THE SECRETARY OF THE ARMY
[Illegible signature and text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06029						06024					
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH					
First Middle Last Claude A Todd						Month Day Year 4 14 1969					
3. SEX Male		4. RACE White		5. DATE OF BIRTH December 5, 1903		6. AGE (In years lost birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Caroline Co., Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Necunaria		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D.	
14. FATHER'S NAME First Middle Last F. Linwood Todd				15. MOTHER'S MAIDEN NAME First Middle Last Ella M. Gossage							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown) NO				16b. SOCIAL SECURITY NO. 217-36-0340		17. INFORMANT Address Lillie M. Todd, Preston, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>myocardial infarction 3-13-69</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-13</u> , 19 <u>69</u> , to <u>4-14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Stephen P. Carney</u>				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/16/69			
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney				22e. ADDRESS M.D. Easton, Maryland 21601							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE April 17, 1969		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City or Town) (County) (State) Federalburg, Maryland					
24. FUNERAL DIRECTOR Frampton Funeral Home, Federalburg, Maryland				ADDRESS		25a. REC'D BY REGISTRAR APR 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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INT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
06030					CERTIFICATE OF DEATH					06025					
1. DECEASED-NAME (Type or print) CHARLES A. TRIBBITT					2a. DATE OF DEATH 4 Month 18 -Day 69 Year 2:45P.M.					2b. HOUR					
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 11-25-77			6. AGE (In years last birthday) 91 YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Delaware			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH TALBOT Md.						
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Farmer			12b. KIND OF BUSINESS OR INDUSTRY None						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Greensboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER None			
14. FATHER'S NAME First William Middle Tribbitt Last Tribbitt					15. MOTHER'S MAIDEN NAME First Henritta Middle Pierson Last Pierson										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. Unknown			17. INFORMANT Leonard Tribbitt Address Greensboro, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Uncertain										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-3-69					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (1) (this hospital) attended the deceased from 4-4 , 19 69 , to 4-18 , 19 69 , that (1) (we) last saw the deceased alive on 4-13 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Robert W. Trever, M.D. DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 4-18-69					
22d. PHYSICIAN'S NAME (Type) R.D. 3 Easton					22e. ADDRESS R.D. 3 Easton										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-20-69			23c. NAME OF CEMETERY OR CREMATORY Greensboro			23d. LOCATION (City or Town) (County) (State) Greensboro, Caroline, Md.						
24. FUNERAL DIRECTOR J. E. Boulais ADDRESS Greensboro, Md.					25a. REC'D BY REGISTRAR APR 22 1969			25b. REGISTRAR'S SIGNATURE Charles Judge							

00030

DEPARTMENT OF DEATH

CHURCHES 2. 10-10-60 2:00 PM

NAME: 11-24-73

DATE OF BIRTH: 11-24-73

DEATH IN THE HOME: 11-24-73

DEATH IN THE HOME: 11-24-73

DEATH IN THE HOME: 11-24-73

DEATH IN THE HOME: 11-24-73

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DEATH IN THE HOME: 11-24-73

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06031

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06027

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
IRVING BENTON VAN WERT						April 13, 1969			3 ²⁸ PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		February 22, 1905			64 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		Md.	
Massachusetts		USA					Talbot County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
St. Michaels			-----			Ret - Sales Rep.			Cement	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Talbot			St. Michaels			Talbot St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Last
Fred Benton VanWert						Cora Dugay				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
No						Dorothy K. VanWert, St. Michaels, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease (Occlusion)</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Elevated blood Cholesterol (according to wife)</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-13-69</u> , 19____, to____, 19____, that (I) (we) last saw the deceased alive on <u>4-13-69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Lester M. Dyke, M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-13-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>LESTER M. DYKE, M. D.</u>					22e. ADDRESS <u>RFD 4, Box 231, Easton, Md 21601</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		April 16, 1969		Olivet Cemetery			St. Michaels Talbot Md.			
24. FUNERAL DIRECTOR <u>Harison E. Leonard, St. Michaels, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>APR 21 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00031

DATE: April 13, 1969 TIME: 10:00 AM

NAME: [illegible] DATE: [illegible]

ADDRESS: [illegible]

PHONE: [illegible]

CITY: [illegible] STATE: [illegible]

EMPLOYER: [illegible]

REASON FOR CALL: [illegible]

REMARKS: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06032

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06028

1. DECEASED-NAME (Type or print) ^{First} MINNIE ^{Middle} VIOLA ^{Last} WARD			2a. DATE OF DEATH ^{Month} 4 ^{Day} 4 ^{Year} 69		2b. HOUR 3p M
3. SEX Female		4. RACE Colored	5. DATE OF BIRTH FEB 17, 1897		6. AGE (In years last birthday) 72 YRS.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN TALBOT	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME ^{First} WILLIAM B. ^{Middle} JOHNSON ^{Last}			15. MOTHER'S MAIDEN NAME ^{First} MARY ELIZA ^{Middle} WOOTERS ^{Last}		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 094-01-5251		17. INFORMANT FLOYD WARD, ST. MICHAELS MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerosis and hypertension DUE TO, OR AS A CONSEQUENCE OF (c) cardio vasd. 4122 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-4-69, to 4-4-69, that (I) (we) last saw the deceased alive on 4-4-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Guy M. Reeser MD				22c. DATE SIGNED 4-7-69	
22d. PHYSICIAN'S NAME (Type) Guy M. Reeser				22e. ADDRESS St. Michaels Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Apr 7, 1969		Thomas Memorial	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	
Harrison E. Leonard		St. Michaels, Md		DATE APR 10 1969	
				25b. REGISTRAR'S SIGNATURE Charles Yunge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06033

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>WILLIAM H. WRIGHTSON</u>			2a. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1969</u>			2b. HOUR <u>11:43</u> AM					
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>JULY 28-1899</u>		6. AGE (In years last birthday) <u>69</u> YRS.		7. UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		8. UNDER 24 HRS. HOURS <u>11</u> MIN <u>43</u>	
7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>TALBOT</u> Md.					
10. CITY OR TOWN OF DEATH <u>EASTON</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>MEMORIAL</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>CARPENTER</u>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNE</u>		13b. CITY OR TOWN <u>QUEENSTOWN</u>		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <u>ROUTE 1</u>		13d. <u>Box 52</u>			
14. FATHER'S NAME First <u>G.</u> Middle <u>G.</u> Last <u>WRIGHTSON</u>		15. MOTHER'S MAIDEN NAME First <u>SUSIE</u> Middle <u>E</u> Last <u>DADDS</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>		16b. SOCIAL SECURITY NO. <u>217-03-3424</u>		17. INFORMANT Address <u>MRS. WRIGHTSON - QUEENSTOWN MD.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u> <u>Unknown</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>< 12 Hrs</u> <u>4-4-69</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic myelocytic leukemia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-5</u> , 19 <u>69</u> , to <u>4-12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert W. Trever M.D.</u>		22c. DATE SIGNED <u>4-13-69</u>		22d. PHYSICIAN'S NAME (Type) <u>Robert W. Trever M.D.</u> 22e. ADDRESS <u>Easton, Maryland 21601</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APRIL 15</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD</u>		23d. LOCATION (City or Town) (County) (State) <u>CENTREVILLE MD.</u>					
24. FUNERAL DIRECTOR <u>Have Funeral Home, Church Hill, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Gage</u>							

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